

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 44-1  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MARY Edna Alexander</b>		2a. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1968</b>		2b. HOUR <b>6:30 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>Feb. 21, 1887</b>	6. AGE (In years lost birthday) <b>81</b> YRS.	IF UNDER 1 YEAR MONTHS <b>81</b> DAYS <b>81</b>
7a. BIRTHPLACE (State or foreign country) <b>md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>SYkesville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Oakland Road</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>SYkesville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>OAKLAND Road</b>
14. FATHER'S NAME First <b>William</b> Middle <b>-</b> Last <b>Tawney</b>		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>Eleanor</b> Last <b>Alexander</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>MR. MARVIN Alexander SYkesville, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/20/68</b> , 1968, to <b>5/21/68</b> , 1968, that (I) (we) last saw the deceased alive on <b>5/20/68</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Wm E. Martin M.D.</b>		22c. DATE SIGNED <b>5/21/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Wm E. Martin MD</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5-24-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old OAKLAND</b>	23d. LOCATION (City or Town) (County) (State) <b>SYkesville Md.</b>
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		ADDRESS <b>SYkesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 27 1968</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

08280

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RECEIVED BY AIRMAIL 10/10/50

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MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Ella Maud Lee ARMACOST</i>			2a. DATE OF DEATH Month Day Year <i>May 10 1968</i>		2b. HOUR <i>12:25 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Feb 1 1894</i>		6. AGE (In years lost birthday) YRS. <i>74</i>	
7a. BIRTHPLACE (State or foreign country) <i>Oxford Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Carroll</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Manchester Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Longview Nursing Home</i>		12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>School Teacher Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>County Schools</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Finksburg</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Reister Rd</i>			
14. FATHER'S NAME First Middle Last <i>John C LEE</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Wilson Rodebaugh</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>214-28-1055</i>		17. INFORMANT Address <i>Ella Lee Armacost (saw) Finksburg Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Atherosclerosis</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac Insufficiency</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4224</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 29</i> , 19 <i>67</i> , to <i>May 10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>May 10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Joseph E Bush</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>May 10, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Joseph E Bush</i>		22e. ADDRESS <i>WAMPSTEAD Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5/13/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FINKSBURG CHURCH CEM. FINKSBURG-CARROLL, MD.</i>	
23d. LOCATION (City or Town) (County) (State) <i>Finksburg Carroll Md</i>					
24. FUNERAL DIRECTOR <i>J. E. Myers, Jr., Westminster, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>MAY 13 1968</i>					

1. Name of the deceased  
2. Age  
3. Sex  
4. Date of death  
5. Time of death  
6. Place of death  
7. Cause of death  
8. Signature of the doctor  
9. Signature of the witness  
10. Signature of the registrar

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06871

06878

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Cora		Elizabeth	Beard		MAY Month 6 Day 1968 Year		3p M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	7/14/83		89 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Carroll Co		USA				Carroll Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Manchester		Long View Nursing Home		Clerk		Clerk		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Baltimore				4513 Arabia Ave		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Edward H Beard		Ida C Caylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Not no		579-60-4611		John Beard		Westminster, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 5 yrs 437.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized Arteriosclerosis</u> 5 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 334X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11/3/1966, to 5/6/1968, that (I) (we) last saw the deceased alive on 4/25/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
W.H. Foward MD		5/6/68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
W.H. Foward M.D.		Manchester, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5/9/68		Pipe Creek Cemetery		New Windsor, Carroll Md		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.E. Myers, Jr., Westminster, Md				MAY 8 1968		J. E. Myers, Jr.		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (and 1) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>FIRST</b> <i>HARVEY</i> <b>MIDDLE</b> <i>EDWARD</i> <b>LAST</b> <i>BEARD</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>5</i> Year <i>1968</i>		2b. HOUR <i>10:45</i> M
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>DEC. 24, 1878</i>		6. AGE (In years last birthday) <i>89</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>CARROLL CO.</i> Md.		
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>CARROLL CO. GEN. HOSP</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>FARMER</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>CARROLL</i>	13c. CITY OR TOWN <i>WESTMINSTER</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>R.D. #3</i>	
14. FATHER'S NAME <b>FIRST</b> <i>EDWARD</i> <b>MIDDLE</b> <i>H.</i> <b>LAST</b> <i>BEARD</i>	15. MOTHER'S MAIDEN NAME <b>FIRST</b> <i>IDA</i> <b>MIDDLE</b> <i>CAYLOR</i> <b>LAST</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. <i>214-78-5608A</i>		17. INFORMANT <i>EARL D. BEARD</i>		Address <i>SAME ADDRESS</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>440.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4500</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 3, 1968</i> , to <i>May 5, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 5, 1968</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John S. Harshey</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5/5/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN S. HARSHEY, MD</i>		22e. ADDRESS <i>8 Anchor St. Westminster, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>5/8/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MEADOW BRANCH CEM.</i>	23d. LOCATION (City or Town) (County) (State) <i>WESTMINSTER CARROLL MD</i>		
24. FUNERAL DIRECTOR <i>J. E. Myers, Jr., Westminster, Md.</i>		ADDRESS <i>Westminster, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 8 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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VR 11-1  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 5/27/68 kk 06880														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
John Cooper Beavin						Month Day Year 5/20/68			6:00 P M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		12/1/06			61 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			U.S.A.						Carroll County			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital						Cook					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Balto. City			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10 E. Pratt Street				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
George F. Beavin			Martha Murphy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address								
None			214-12-2906			Records, Springfield State Hospital								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Pneumonia												days		
1538 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of (S) colon												months		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Schizophrenic reaction, paranoid type, alcoholism.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State					
						Street or R.F.D. No.								
22a. I certify that (I) (this hospital) attended the deceased from 7/31/1957, to 5/20/1968, that (I) (we) last saw the deceased alive on 5/20/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE									22c. DATE SIGNED					
Carlos G. Lavin									5/20/68					
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS					
Carlos G. Lavin									Springfield State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			5/24/68		New Cathedral Cemetery			Baltimore, Maryland						
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Frank W. Seitz Funeral Home Balto. Md.						DATE MAY 27 1968		Charles Judge						

07350

07350



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

411  
06874  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

06881

1. DECEASED-NAME (Type or print) <b>ANNIE MARIE BLESSING</b>		First Middle Last		2a. DATE OF DEATH <b>May 27</b> Day <b>1968</b> Year <b>10<sup>35</sup></b> M	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>NOV. 5, 1884</b>		6. AGE (In years last birthday) <b>83</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>CARROLL CO.</b>		Md.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL CO. GEN. HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE-WIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>19 JOHN ST.</b>			
14. FATHER'S NAME First Middle Last <b>ALBERT SCHUCHART</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY CATHERINE HUFNAGLE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>220-18-1420B</b>		17. INFORMANT <b>Mrs. Wm. H. Blessing</b> Address <b>SAME ADDRESS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>4201</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 27, 1968</b> , to <b>May 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John S. Harshey</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/27/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY M.D.</b>		22e. ADDRESS <b>8 Ancho St. Westminster, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN MEM. GARDENS FINKSBURG, MD.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Westminster, Md.</b>					
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr. Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1832

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 12 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A1571  
30M REV. 7-1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Maurice D Bransfield			2a. DATE OF DEATH Month Day Year May 24 1968				2b. HOUR 11 <sup>45</sup> AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb 26 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Manchester Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Longview Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Garage			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Reisterstown Md		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 214 MAIN ST.	
14. FATHER'S NAME First Middle Last Jasper Bransfield			15. MOTHER'S MAIDEN NAME First Middle Last Annie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 215-22-9047		17. INFORMANT D Joseph Bransfield		Address Reisterstown Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH May 21 68									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 11, 1968, to May 24, 1968, that (I) (we) last saw the deceased alive on May 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph E Bush MD		22c. DATE SIGNED May 24, 1968		22d. PHYSICIAN'S NAME (Type) Joseph E Bush MD		22e. ADDRESS 104 Hampstead Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Finksburg, Carroll, Md.			
24. FUNERAL DIRECTOR H. J. Schhardt		ADDRESS Owings Mills, Md.		25a. REGD BY REGISTRAR DATE May 27 1968		25b. REGISTRAR'S SIGNATURE Judge			

28331

ROAD TO WAREHOUSE

28330

*[Faint, illegible handwritten text, possibly a list or notes, covering the majority of the page.]*



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First			Middle			Last		
ROBERT			JUNIOR			BROOKSHIRE			SR		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Nov. 1, 1928		39 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		2a. DATE KNOWN OF DEATH		2b. HOUR	
N. Carolina		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll		5/24 1968		8:00 PM	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			R.D. 3			Auto Mechanic					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Carroll			Sykesville			R.D. 3		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Robert A. Brookshire			Viola			No			229-34-5778		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. DATE OF OPERATION			20. AUTOPSY?		
Robert A. Brookshire			Coronary Thrombosis (acute)			3032			Short time		
			Chronic Alcoholism						Several years		
			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			3221					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		
CAUSE OF DEATH			P.M.			19					
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)		
ACTUAL SIGNATURE			5-24-68			Bethesda Cemetery			Carroll Co., Md.		
EXAMINER'S NAME (Type)			Dr. W. Glenn Speicher			DEPUTY MEDICAL EXAMINER			Charles Judge		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/27/1968			Bethesda Cemetery			Carroll Co., Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE		
C. M. Waltz, Box 241, Sykesville, Md.			MAY 28 1968			Charles Judge					

012525

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

06884

1. DECEASED-NAME (Type or print) <b>Murriel E.</b>		First Middle Last		2a. DATE OF DEATH <b>May 27 1968</b>		2b. HOUR <b>7:50a</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 20, 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hampstead</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Main St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Sparks</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>Stringtown Rd.</b>		14. FATHER'S NAME First Middle Last <b>Samuel Bull</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Beulah Shaffer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>216-07-5732</b>		17. INFORMANT Address <b>Mrs. Evelyn Bull Sparks, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arterio-Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 min.</b> <b>1 1/2 years</b> <b>5 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1967</b> , to <b>May 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M.C. Porterfield, M.D.</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-27-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield, M.D.</b>				22e. ADDRESS <b>HAMPSTEAD, Md.</b>			
23a. BURIAL, CREMATION, (specify) <b>Burial</b>		23b. DATE <b>May 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Upperco, Balto. Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Tipton -Eline Funeral Home Hampstead, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES

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Internal

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 153 (1)  
30M REV. 1/68

008878										06885																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
MARGIE VIRGINIA CAPLE										Month Day Year					9 P M														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
FEMALE					WHITE					AUG 6, 1900					67 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
CARROLL CO. MD.					U.S.A.										CARROLL CO.					Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
WESTMINSTER					RT#4, REESE					HOUSE - WIFE																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					CARROLL					WESTMINSTER										RT#4 REESE									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
J. WILLIAM MANN					MINAH BUCKINGHAM																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
										MR. LESTER U. CAPLE					SAME ADDRESS														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Atherosclerosis / Heart Disease</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b)																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
4200																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>present</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.																													
22b. SIGNATURE <u>John S. Harshey, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED <u>5/20/68</u>														
22d. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>															22e. ADDRESS <u>8400 St. Westminster, Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					5/22/68					SANDY MOUNT CEM					FINKSBURG CARROLL MD														
24. FUNERAL DIRECTOR <u>L.S. Myers, Jr., Westminster, Md.</u> ADDRESS															25a. REC'D BY REGISTRAR DATE <u>MAY 24 1968</u>					25. REGISTRAR'S SIGNATURE <u>Judge</u>									







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 4-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Lucius Benjamin CARTER</b>			2a. DATE OF DEATH Month Day Year <b>May 19, 1968</b>			2b. HOUR <b>6 a M</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>9-2-1882</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>retired forester</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland 21504</b>		13b. COUNTY <b>Allegheny</b>		13c. CITY OR TOWN <b>LaVale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Oaklawn Avenue</b>		
14. FATHER'S NAME First Middle Last <b>PAYTON R. CARTER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Marie Beatty - dec.</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-32-3579</b>		17. INFORMANT <b>Springfield State Hosp., Sykesville, Md.</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>437.9</b> IMMEDIATE CAUSE (a) <b>Cerebral insufficiency.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>355X</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome assoc. with psychotic reaction.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>5-17-68</b> , 19____, to <b>5-19-68</b> , 19____, that (we) last saw the deceased alive on <b>5-19-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Ramon P. Lopez</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>5-19-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND MD.</b>				
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>FLORENCE MILDRED COLE</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>?</b> M <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 9, 1904</b>		6. AGE (in years last birthday) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hampstead</b>				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Houcksville Rd.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Houcksville Rd.</b>	
14. FATHER'S NAME First <b>Benjamin</b> Middle <b>Taylor</b> Last <b></b>						15. MOTHER'S MAIDEN NAME First <b>Addie</b> Middle <b>Blizzard</b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>220-24-7006</b>		17. INFORMANT ADDRESS <b>T. Harvey Cole Hampstead, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>953X</b> (b) <b>Depression</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1 hr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>979X</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>5-29</b> 19 <b>68</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Crawled into Refrigerator and closed door</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Her Home</b>		21f. LOCATION Street or R.F.D. No. <b>Houcksville Rd. Hampstead</b>		City or Town <b>Carroll</b>		County <b>Md</b>		State <b></b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>5-29-68</b>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city or town, or county) <b>1356 Main Westminster Md</b>			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE <b>June 1, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Cem.</b>		23d. LOCATION (City or Town) <b>Finksburg</b>		County <b>Carroll</b>		State <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				ADDRESS				25a. REC'D BY REGISTRAR DATE <b>JUN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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• *Journal of the American Medical Association* 277:1033-1034, 1997

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First <b>Minerva</b>			Middle <b>R.</b>			Last <b>Cressman</b>			2a. DATE OF DEATH Month <b>May</b>			Day <b>1</b>			Year <b>1968</b>			2b. HOUR <b>6:45</b> AM		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>12/13/1890</b>			6. AGE (In years last birthday) <b>77</b> YRS.			IF UNDER 1 YEAR MONTHS <b>77</b>			IF UNDER 24 HRS. HOURS <b>77</b>			MIN. <b>77</b>					
7a. BIRTHPLACE (State or foreign country) <b>Montgomery Co. Pa.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b>			Md.											
10. CITY OR TOWN OF DEATH <b>R.D.2, Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Meadow View Convalescent Home.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife-Housework</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own home.</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pennsylvania</b>			13b. COUNTY <b>Adams</b>			13c. CITY OR TOWN <b>R.D.2 Littlestown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER											
14. FATHER'S NAME First <b>William</b>			Middle <b>S</b>			Last <b>Ott</b>			15. MOTHER'S MAIDEN NAME First <b>Lizzie</b>			Middle <b>D.</b>			Last <b>Dorn</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>197-26-5938</b>			17. INFORMANT <b>Mrs. James M. Anthony, Littlestown, Pa. R-2</b>			Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4249</b> IMMEDIATE CAUSE (a) <b>Valvular Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4214</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Advanced generalized arthritis</b>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1964</b> , to <b>May 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>Julius Chepko M.D.</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>5/1/68</b>								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>5/4/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>The Hillside Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Souderton, Montgomery Co., Pa.</b>														
24. FUNERAL DIRECTOR <b>Richard A. Little</b>			ADDRESS <b>Littlestown, Pa.</b>			25a. REC'D BY REGISTRAR DATE <b>MAY 2 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First Middle Last <b>PAUL M. DOXZON</b>			2a. DATE OF DEATH Month Day Year <b>May 22, 1968</b>		2b. HOUR <b>8:30PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-11-1898</b>		6. AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll County Md.</b>		
10. CITY OR TOWN OF DEATH <b>Eldersburg</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Box 195 Liberty Road</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Asst. Boss</b>	12b. KIND OF BUSINESS OR Co. INDUSTRY <b>Con. Engineer</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Carroll Co.</b>	13c. CITY OR TOWN <b>Eldersburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Box 195 Liberty Road</b>	
14. FATHER'S NAME First Middle Last <b>JOHN DOXZON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Elizabeth (Unknown)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-09-9855</b>	17. INFORMANT Address <b>Mrs. Rachel A. Doxzon, Box 195 Liberty Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung, cerebral metastasis.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchial pneumonia, anemia and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac arrest.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Feb. 1968 through May 22, '68</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163X</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>68</b> , to <b>May 22</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 22</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Howard E. Hall Jr</b>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>May 22, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Howard E. Hall, M.D.</b>	22e. ADDRESS <b>Sykesville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-25-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Maryland</b>		
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 27 1968</b>	25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>JACOB WILBUR DRAWBAUGH</b>						2a. DATE OF DEATH Month Day Year <b>5 16 68</b>			2b. HOUR MIN <b>5 30 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>OCT. 16 1896</b>			6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.						
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL CO. GENERAL LUTHEREAN MINISTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>COCKEYSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>WESTERN RUN ROAD RT#1 BOX 28</b>		
14. FATHER'S NAME First Middle Last <b>ELI C. DRAWBAUGH</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>DELLA RIDER</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>216-20-3419</b>		17. INFORMANT <b>MRS. MARY L. DRAWBAUGH, RT#1 Box 28</b>				Address <b>COCKEYSVILLE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE ANTERIOR MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>YEARS</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17, 1968</b> , to <b>5/16, 1968</b> , that (I) (we) last saw the deceased alive on <b>5/16 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Theresa J. Brown, M.D.</b>						22c. DATE SIGNED <b>5/16/68</b>						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHOOP'S CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HARRISBURG, PA.</b>						
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster Md.</b>						25a. REC'D BY REGISTRAR <b>MAY 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MEDICAL CERTIFICATION

X

5833

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Harry Smith Engler</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>3:10 PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 25, 1908</b>		6. AGE (In years last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b>				
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>133 PENNA. AVE.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>133 PENNA. AVE.</b>	
14. FATHER'S NAME First Middle Last <b>HARRY E. ENGLAR</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MAMIE ELIZABETH SMITH</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>218-34-0150</b>			17. INFORMANT <b>MRS H. SMITH ENGLAR</b>			Address <b>SAME ADDRESS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 months</b> <b>1964</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Massive C.V.A. 1964</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>April 1964</b> , to <b>5/25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.										
22b. SIGNATURE <b>William R. Roubek</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5/25/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>W. MAIN ST. WESTMINSTER, MD</b>						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>5/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>NEW WINDSOR, CARROLL MD</b>		
24. FUNERAL DIRECTOR <b>J. S. Mingo, Jr. Westminster, Md</b>						25a. REC'D BY REGISTRAR DATE <b>MAY 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

WASH DC 20540

10230

10230



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

<div style="text-align: center;"> <p>06885</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">06892</p> </div>											
1. DECEASED-NAME (Type or print) <i>Emma Beniller Zieser</i>			First Middle Last			10. DATE OF DEATH <i>May</i> Month <i>14</i> Day <i>1968</i> Year			2b. HOUR <i>4:30</i> P.M.		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 10, 1886</i>			6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Teacher</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Shoe</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Union Mills</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <i>John Beniller</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth Wolge</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) <i>None</i>			16b. SOCIAL SECURITY NO. <i>213-05-1659A</i>		17. INFORMANT <i>Miss Margaret Petry Rt 7 Box 311 Westminster, Md</i>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1750</i> (b) <i>Ovarian Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Cardiovascular Disease</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-13-68</i> , to <i>5-14-68</i> , that (I) (we) last saw the deceased alive on <i>5-14-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles Mawhinney Jr. M.D.</i>						22c. DATE SIGNED <i>5-14-68</i>			22d. PHYSICIAN'S NAME (Type)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>5-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadow Branch</i>			23d. LOCATION (City or Town) (County) (State) <i>Westminster Carroll Md</i>			
24. FUNERAL DIRECTOR <i>J. J. Myers, Jr., Westminster, Md</i>						25a. REC'D BY REGISTRAR DATE <i>MAY 20 1968</i>			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

28800

STANDARD

28800

5th

3d

1st

2nd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

06886				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06893					
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
HENRIETTA				FEHLE				Month 5 Day 10 Year 68				4 30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Jan. 5, 1895				73 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U.S.A.				Carroll Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. Gen. Hospital						Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Carroll		New Windsor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 1			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Frederick W. Hohman				Caroline Bauernschmidt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No				212-05-2839B		Mr. Charles R. Fehle Same As # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT										6 DAYS			
436.0 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE VASCULAR DISEASE										YEARS			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
331X													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 5/14, 1968, to 5/10, 1968, that (I) (we) last saw the deceased alive on 5/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE										22c. DATE SIGNED			
Dr. Vincent J. Fiocco M.D. DEGREE										5/10/68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
Dr. Vincent J. Fiocco				Westminster, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		5/13/1968		Evergreen Mem. Gardens		Carroll, Md.							
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
C. M. Waltz, Box 241, Sykesville, Md.				MAY 13 1968		Charles Judge							

NAME		ADDRESS		CITY		STATE	
J. H. Smith		123 Main St		New York		NY	
W. J. Brown		456 Elm St		Chicago		IL	
M. L. Green		789 Oak St		Los Angeles		CA	
R. K. White		101 Pine St		San Francisco		CA	
S. P. Black		202 Cedar St		Boston		MA	
T. Q. Yellow		303 Birch St		Philadelphia		PA	
V. R. Purple		404 Spruce St		Seattle		WA	
X. S. Blue		505 Willow St		Portland		OR	
Y. T. Red		606 Ash St		Denver		CO	
Z. U. Grey		707 Hickory St		Austin		TX	
A. V. Green		808 Maple St		Dallas		TX	
B. W. Brown		909 Cedar St		Houston		TX	
C. X. White		1010 Oak St		San Antonio		TX	
D. Y. Black		1111 Pine St		Fort Worth		TX	
E. Z. Yellow		1212 Birch St		El Paso		TX	
F. A. Purple		1313 Spruce St		Phoenix		AZ	
G. B. Blue		1414 Willow St		Tucson		AZ	
H. C. Red		1515 Ash St		Albuquerque		NM	
I. D. Grey		1616 Hickory St		Santa Fe		NM	
J. E. Green		1717 Maple St		Las Vegas		NV	
K. F. Brown		1818 Cedar St		Reno		NV	
L. G. White		1919 Oak St		Salt Lake City		UT	
M. H. Black		2020 Pine St		Denver		CO	
N. I. Yellow		2121 Birch St		Colorado Springs		CO	
O. J. Purple		2222 Spruce St		Ft. Collins		CO	
P. K. Blue		2323 Willow St		Boulder		CO	
Q. L. Red		2424 Ash St		Greeley		CO	
R. M. Grey		2525 Hickory St		Windsor		CO	
S. N. Green		2626 Maple St		Longmont		CO	
T. O. Brown		2727 Cedar St		Louisville		KY	
U. P. White		2828 Oak St		Lexington		KY	
V. Q. Black		2929 Pine St		Cincinnati		OH	
W. R. Yellow		3030 Birch St		Columbus		OH	
X. S. Purple		3131 Spruce St		Dayton		OH	
Y. T. Blue		3232 Willow St		Akron		OH	
Z. U. Red		3333 Ash St		Cleveland		OH	
A. V. Grey		3434 Hickory St		Detroit		MI	
B. W. Green		3535 Maple St		Ann Arbor		MI	
C. X. Brown		3636 Cedar St		Flint		MI	
D. Y. White		3737 Oak St		Livonia		MI	
E. Z. Black		3838 Pine St		Farmington Hills		MI	
F. A. Yellow		3939 Birch St		Westland		MI	
G. B. Purple		4040 Spruce St		Dearborn		MI	
H. C. Blue		4141 Willow St		Livonia		MI	
I. D. Red		4242 Ash St		Farmington Hills		MI	
J. E. Grey		4343 Hickory St		Westland		MI	
K. F. Green		4444 Maple St		Dearborn		MI	
L. G. Brown		4545 Cedar St		Livonia		MI	
M. H. White		4646 Oak St		Farmington Hills		MI	
N. I. Black		4747 Pine St		Westland		MI	
O. J. Yellow		4848 Birch St		Dearborn		MI	
P. K. Purple		4949 Spruce St		Livonia		MI	
Q. L. Blue		5050 Willow St		Farmington Hills		MI	
R. M. Red		5151 Ash St		Westland		MI	
S. N. Grey		5252 Hickory St		Dearborn		MI	
T. O. Green		5353 Maple St		Livonia		MI	
U. P. Brown		5454 Cedar St		Farmington Hills		MI	
V. Q. White		5555 Oak St		Westland		MI	
W. R. Black		5656 Pine St		Dearborn		MI	
X. S. Yellow		5757 Birch St		Livonia		MI	
Y. T. Purple		5858 Spruce St		Farmington Hills		MI	
Z. U. Blue		5959 Willow St		Westland		MI	
A. V. Red		6060 Ash St		Dearborn		MI	
B. W. Grey		6161 Hickory St		Livonia		MI	
C. X. Green		6262 Maple St		Farmington Hills		MI	
D. Y. Brown		6363 Cedar St		Westland		MI	
E. Z. White		6464 Oak St		Dearborn		MI	
F. A. Black		6565 Pine St		Livonia		MI	
G. B. Yellow		6666 Birch St		Farmington Hills		MI	
H. C. Purple		6767 Spruce St		Westland		MI	
I. D. Blue		6868 Willow St		Dearborn		MI	
J. E. Red		6969 Ash St		Livonia		MI	
K. F. Grey		7070 Hickory St		Farmington Hills		MI	
L. G. Green		7171 Maple St		Westland		MI	
M. H. Brown		7272 Cedar St		Dearborn		MI	
N. I. White		7373 Oak St		Livonia		MI	
O. J. Black		7474 Pine St		Farmington Hills		MI	
P. K. Yellow		7575 Birch St		Westland		MI	
Q. L. Purple		7676 Spruce St		Dearborn		MI	
R. M. Blue		7777 Willow St		Livonia		MI	
S. N. Red		7878 Ash St		Farmington Hills		MI	
T. O. Grey		7979 Hickory St		Westland		MI	
U. P. Green		8080 Maple St		Dearborn		MI	
V. Q. Brown		8181 Cedar St		Livonia		MI	
W. R. White		8282 Oak St		Farmington Hills		MI	
X. S. Black		8383 Pine St		Westland		MI	
Y. T. Yellow		8484 Birch St		Dearborn		MI	
Z. U. Purple		8585 Spruce St		Livonia		MI	
A. V. Blue		8686 Willow St		Farmington Hills		MI	
B. W. Red		8787 Ash St		Westland		MI	
C. X. Grey		8888 Hickory St		Dearborn		MI	
D. Y. Green		8989 Maple St		Livonia		MI	
E. Z. Brown		9090 Cedar St		Farmington Hills		MI	
F. A. White		9191 Oak St		Westland		MI	
G. B. Black		9292 Pine St		Dearborn		MI	
H. C. Yellow		9393 Birch St		Livonia		MI	
I. D. Purple		9494 Spruce St		Farmington Hills		MI	
J. E. Blue		9595 Willow St		Westland		MI	
K. F. Red		9696 Ash St		Dearborn		MI	
L. G. Grey		9797 Hickory St		Livonia		MI	
M. H. Green		9898 Maple St		Farmington Hills		MI	
N. I. Brown		9999 Cedar St		Westland		MI	
O. J. White		10000 Oak St		Dearborn		MI	

Vertical text on the right margin, likely a list of names or addresses, mostly illegible due to fading.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) <b>LOTTIE GRACE FIDLER</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>10</b> Year <b>1968</b>		2b. HOUR <b>3:00</b> M <b>P</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11 Feb 1889</b>	6. AGE (In years last birthday) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Wrightsville, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.
10. CITY OR TOWN OF DEATH <b>Mount Airy</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>730 N. Main St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House-work</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Mt. Airy</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>Samuel V. Knisley</b> Middle <b>Samuel V. Knisley</b> Lost <b>Samuel V. Knisley</b>		15. MOTHER'S MAIDEN NAME First <b>Mary C. Frey</b> Middle <b>Mary C. Frey</b> Lost <b>Mary C. Frey</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>
16b. SOCIAL SECURITY NO. <b>219-03-7383</b>		17. INFORMANT <b>Mrs. Pearl F. Gendell</b>		ADDRESS <b>730 N. Main St., Mt. Airy, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> Sudden <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hypertension &amp; Arteriosclerosis</b> 20 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <b>20 yrs</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>1355</b> City or Town <b>Mount Airy</b> County <b>Carroll</b> State <b>Md.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10 May 1968</b>
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS <b>1355</b> City or Town <b>Mount Airy</b> County <b>Carroll</b> State <b>Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/14/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) <b>Wrightsville, Pa.</b> (County) <b>Carroll</b> (State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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Female White 11 Feb 1889 79

Wrightsville, Pa. U. S. X Carroll

Mount Airy 730 N. Main St. House-work 730 N. Main St.

Carroll Mt. Airy 730 N. Main St.

Samuel V. Knisley Mary C. Gray

219-02-7343 Mrs. H. Carroll 730 N. Main St. Mt. Airy, Pa.

10 May 1968

A. Glenn Spencer, U. S.

Burial 5/14/68 Review Cemetery Wrightsville, Pa.

A. A. Robinson & Son, Frederick, Md. 21701



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First <b>Nellie</b>		Middle <b>Mae</b>		Last <b>Flock</b>		2a. DATE OF DEATH <b>5</b> Month <b>1</b> Day <b>68</b> Year		2b. HOUR <b>2:20</b> PM		
3. SEX <b>female</b>			4. RACE <b>white</b>			5. DATE OF BIRTH <b>5/30/02</b>			6. AGE (In years lost birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Janitress</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Frederick</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>526 Wilson Place</b>		
14. FATHER'S NAME First <b>Frank</b>			Middle <b>W.</b>		Last <b>Smith</b>		15. MOTHER'S MAIDEN NAME First <b>Daisy</b>			Middle <b>A.</b>		Last <b>Martin</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-40-4839</b>			17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4221</b> (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>  <b>years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic brain syndrome with presenile brain disease without qualifying phrase.</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>7/21/1963</b> , to <b>5/1/1968</b> , that <del>it</del> (we) last saw the deceased alive on <b>5/1/1968</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (does) view the body after death.													
22b. SIGNATURE <b>Renato R. Espina</b>			REGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>5/1/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>			22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>May 4, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon</b>			23d. LOCATION (City or Town) <b>Balto, Md.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Paul E. Chenoweth Jr. 3617 Chestnut Ave</b>						25a. REC'D BY REGISTRAR DATE <b>MAY 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Bureau", "London", and "1906" are visible.]*

*[Vertical text on the right margin, possibly a file number or reference code.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A157  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR AM PM	
JOHN		WESLEY	FOSSETT	MAY 28, 1968		10:30 AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	Negro		9-22-1888		79 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Carroll Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville		Springfield State Hospital		Carpenter (retired)		Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Howard		Cooksville		None		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		Address				
John		Fossett		Miranda Plumber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				
No		Unk.		Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease and old infarct 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Bronchopneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years Day								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5-13-68, 19__, to 5-28-68, 19__, that (I) (we) lost saw the deceased alive on 5-28-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Octavio A. Ruiz						22c. DATE SIGNED 5-28-68		
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5-31-68		Bushey Park		Cooksville, Md.		
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

AP

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>EDWARD</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>5-12 1968</b>			2b. HOUR OF DEATH <b>4:30 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 24, 1935</b>		6. AGE (In years last birthday) <b>32</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Westminster</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Gen. Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mould-Maker</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Carroll</b>				13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>366 Bear Branch Rd.</b>				14. FATHER'S NAME First Middle Last <b>Eduard Fuchs, Sr.</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Pauline Eberhart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>Korean 216-38-3971</b>				17. INFORMANT <b>Mrs. Rose A. Fuchs</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>916 X asphyxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pressure on Chest</b> (c) <b>Pressure on Chest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>9100</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>5-12 1968 4:30 P.M.</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18) <b>guck slipped and fell on chest</b>			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No. City or town County State <b>Bear Branch Rd. Rd 6 Westminster Md</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>5-12-68</b>			
EXAMINER'S NAME (Type) <b>Dr. W. Glenn Speicher</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				105 E. Main Westminster Carroll Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/16/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Mem. Gardens</b>				23d. LOCATION (City or Town) (County) <b>Carroll, Md.</b>			
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>						25a. REC'D BY REGISTRAR <b>MAY 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Dorothy Gertrude FURLONG						May, 19, 1968		8:55am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
female		white		7-5-1893		74 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Clerk (retired)				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland 21218					Baltimore				1101 Gorsuch Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Michael G. Furlong - dec.			Mary Byrnes - dec.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			220-20-8581A		Springfield State Hosp., Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism, source unknown.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>465X</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>5-6-68</u> , 19 <u>68</u> , to <u>5-19-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-19-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Antonius Glahn</u> DEGREE						22c. DATE SIGNED ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS.		5-19-68		
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		May 22, 1968		St. Marys Cem.		Govans, Md.				
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Road-21212						25a. REC'D BY REGISTRAR DATE MAY 27 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

06892

06899

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY in 1b <u>7 mo. 4 d.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1801 BAKER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Hester</u> Last <u>GREGORY</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1968</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-00</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARLEY DANIELS</u>				14. MOTHER'S MAIDEN NAME <u>LILA DAVIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-10-7429</u>		17. INFORMANT <u>SPRINGFIELD HOSP. RECORDS, SYKESVILLE, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4129</u> IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4221</u> (b) <u>ASCVD</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-20, 1967</u> , to <u>5-24, 1968</u> , that (I) (we) last saw the deceased alive on <u>5-24 1968</u> , and that death occurred at <u>6:30 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Isak Hapner</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>ISAK HAPNER</u>				22d. ADDRESS <u>SPRINGFIELD STATE HOSPITAL, SYKESVILLE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-28-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>Geo. F. Kelsen 1348 N. Calhoun St.</u>				25a. REC'D BY REGISTRAR <u>MAY 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

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UNITED STATES OF AMERICA

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100000 2-28-68 Mt. Colverly Dam, Idaho, Mt.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ROSA ( ROSE )</b>		First	Middle	Lost	2a. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1968</b>		2b. HOUR <b>3:40</b> A <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Unk.</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b>73</b> DAYS <b>73</b>
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Cook</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2927 Walbrook Ave.</b>
14. FATHER'S NAME First <b>Unk.</b>		Middle		Lost		15. MOTHER'S MAIDEN NAME First <b>Unk.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-54-8928</b>		17. INFORMANT <b>MR. LOUIS BUFFENSTEIN. 4270 STUART AVE. RICHMOND, VA</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>403 X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Nephrosclerosis</b> <b>446 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Schizophrenic reaction, paranoid type</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-24-38</b> , 19__, to <b>5-25-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-25-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Dr. Antonius Glahn</b>						22c. DATE SIGNED <b>5-28-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M. D.</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW MT. CARMEL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CIDDY</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>68</b>		2b. HOUR <b>6:00</b> M
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>3/27/67</b>			6. AGE (In years lost birthday) <b>1</b> YRS.	IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b> HOURS <b>1</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL COUNTY</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DR. #4 DREAM LD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>0</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>	13c. CITY OR TOWN <b>WESTMINSTER</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>RT #4 DREAM LD</b>		
14. FATHER'S NAME First <b>PAUL</b> Middle <b>M.</b> Last <b>HAHN JR.</b>		15. MOTHER'S MAIDEN NAME First <b>JANICE</b> Middle <b>JENNINGS</b> Last <b>JENNINGS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT Address <b>Paul M. Hahn, Jr. Same As #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE LYMPHATIC LEUKEMIA</b> <b>2040</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2043</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>GENERALIZED BLEEDING DIATHESIS, SPOTTERMIA</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 21, 1967</b> , to <b>MAY 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>5/27/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sherman S. Chang</b>		22c. DATE SIGNED <b>5/27/68</b>		22d. ADDRESS <b>Westminster, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/30/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leisters Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Co., Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C. M. Waltz, Box 241, Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
IRWIN ROSS HELTIBRIDLE						May Month 4 Day 1968 Year		9:25 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		NOV. 22 1893		74 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				CARROLL Co. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
WESTMINSTER			CARROLL CO. GEN. HOSP.			FARMER AND DAIRY WORKER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			CARROLL		WESTMINSTER		YES		R.D. #7 Box 75	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
SAMUEL HELTIBRIDLE			MARGARET BOWERSOX							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			218-24-1566A		EVELYN W. HELTIBRIDLE ADDRESS SAME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 4109 Coronary thrombosis									12 hours	
DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from May 4, 1968, to May 4, 1968, that (I) (we) last saw the deceased alive on May 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
John S. Harshey, M.D.								5/4/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
JOHN S. HARSHEY, M.D.		Shenandoah St. Westminster, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		5/7/68		FRIZZLEBURG CHURCH CEMETERY		WESTMINSTER RD #7				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
J. S. Myers, Jr., Westminster, Md.				DATE MAY 8 1968		Charles J. [Signature]				

8/92

STATE OF TEXAS

4030

IN SENATE,  
January 10, 1902.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1901.  
BY  
J. M. HARRIS,  
COMMISSIONER.  
DALLAS: THE TEXAS BOOK CONCERN, 1902.

U.S. GOVERNMENT PRINTING OFFICE: 1902.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

06903

1. DECEASED-NAME (Type or print) First Middle Last MARY MARGARET HUNTER			2a. DATE OF DEATH Month Day Year MAY 1 68		2b. HOUR 7:45 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 14, 1906		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CARROLL CO. Md.		
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2 MALCOLM DRIVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MUSIC EDUCATOR		12b. KIND OF BUSINESS OR INDUSTRY COLLEGE
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL	13c. CITY OR TOWN WESTMINSTER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2 MALCOLM DRIVE
14. FATHER'S NAME First Middle Last WILLIAM MALCOLM		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE THOMAS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 219-30-4955		17. INFORMANT GEORGE N. HUNTER Address 234 HIGHMEADOW RD REISTERSTOWN, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rectum c metastasis</u> 1541 DUE TO, OR AS A CONSEQUENCE OF <u>cachexia</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 154X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1962, to May 1, 1968, that (I) (we) last saw the deceased alive on May 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE William Speicher M.D.				22c. DATE SIGNED 5-2-68	
22d. PHYSICIAN'S NAME (Type) William Speicher				22e. ADDRESS 135 E. Wayne Westminister Md 21157	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 4, 1968	23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEMETERY		23d. LOCATION (City or Town) (County) (State) WESTMINSTER MD
24. FUNERAL DIRECTOR S. S. Myers, Jr., Westminister Md.			25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

06897

06904

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>			c. LENGTH OF STAY IN 1b <b>30yr. 10m. 10d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>--</b> Last <b>Izat</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>19 68</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/91</b>		9. AGE (In years last birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Cuthbertson</b>				14. MOTHER'S MAIDEN NAME <b>Parks</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-07-5325</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4129</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4330</b> (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic Cardio Vascular disease</b> yrs. INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>hrs.</b> <b>yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, depressed type.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>at</del> (this hospital) attended the deceased from <b>7/22/</b> , 19 <b>37</b> , to <b>5/22/</b> , 19 <b>68</b> , that <del>in</del> (we) last saw the deceased alive on <b>5/22/1968</b> , and that death occurred at <b>10:25 a.m.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Renato R. Espina</b> M.D.				22b. DATE SIGNED <b>5/22/68</b>		22c. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>	
22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lonaconing, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>JENKIN Marjorie Collison Jenkins</b>		First Middle Last <b>W.</b>		2a. DATE OF DEATH <b>5-26-68</b> Month Day Year		2b. HOUR <b>5:50a</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-24-17</b>		6. AGE (In years lost birthday) <b>50</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland Balto.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield St. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <b>William Waters</b>		First Middle Last		15. MOTHER'S MAIDEN NAME <b>Helen V. Collison</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>223-03-0088</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Urinary tract infection</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>609x Coronary Artery Disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-6-65</b> , 19__, to <b>5-26-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-26-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Gracito V. Patricio</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5/26/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Gracito V. Patricio</b>				22e. ADDRESS <b>Springfield St. Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Md.</b>	
24. FUNERAL DIRECTOR <b>Loring Byers</b>				ADDRESS <b>8728 Liberty Road Randallstown, Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 31 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

06906

1. DECEASED-NAME (Type or print) <b>BERTIE</b> First <b>E</b> Middle <b>KROLL</b> Last			2a. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1968</b>		2b. HOUR <b>3P</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 5/1885</b>		6. AGE (in years lost birthday) <b>83</b> YRS.	
7a. BIRTHPLACE (State, or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Carroll</b>		Md.			
10. CITY OR TOWN OF DEATH <b>Manchester</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>128 N. Main St Long View Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Reisterstown MD</b>	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>Old Hammer Rd RD#3</b>			
14. FATHER'S NAME First <b>John</b> Middle <b>HARRY</b> Last			15. MOTHER'S MAIDEN NAME First <b>Susan</b> Middle <b>BARNES</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>216-09-8620</b>		17. INFORMANT <b>Mr Dolly Murray</b> Address <b>RD#3 Bix 59 Reisterstown MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4221					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> FOR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 6</b> , 19 <b>68</b> , to <b>May 9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph E. Bush</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>May 9, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush MD</b>		22e. ADDRESS <b>Hampstead Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Oakland</b>	
23d. LOCATION (City or Town) <b>Hicksville, Carroll, Md</b>		23e. (County) <b>Carroll</b>		23f. (State) <b>Md</b>	
24. FUNERAL DIRECTOR <b>Robert H. Haight</b>		ADDRESS <b>Hicksville, Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAY 5 1968</b>			

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CELESTIAL V. 0-410

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>LYDIA ELLEN LEPPA.</b>		First Middle Last		2a. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>68</b>		2b. HOUR <b>8<sup>35</sup></b> AM	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>DEC. 7. 1885</b>		6. AGE (In years last birthday) <b>82</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>CARROLL CO. MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL COUNTY</b> Md.	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL COUNTY GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>24 PENNSYLVANIA AVE.</b>		14. FATHER'S NAME First Middle Last <b>WILLIAM R YINGLING</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ELLEN TRISH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-46-6117</b>		17. INFORMANT <b>MRS. Anna Rae Barnhart</b>		Address <b>179 Longview Ave. Westminster, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOVASCULAR DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 WKS</b> <b>YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443X BRONCHOPNEUMONIA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/16</b> , 19 <b>68</b> , to <b>5/6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/6</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Vincent J. Fiocco, MD</b>				22c. DATE SIGNED <b>5/6/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>VINCENT J. FIOCCO, MD</b>				22e. ADDRESS <b>ANCHOR ST. WESTMINSTER, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRIDERS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER CARROLL MD</b>	
24. FUNERAL DIRECTOR <b>James G. Siffel</b>		ADDRESS <b>WESTMINSTER, MD</b>		25a. REC'D BY REGISTRAR <b>MAY 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Charles A. Litsinger</b>					2a. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>10:25</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 26, 1898</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Balto. City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Street Car operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B.T.C.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Manchester</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>202 York St.</b>	
14. FATHER'S NAME First Middle Last <b>John Litsinger</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Clemens</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>213-10-2817</b>		17. INFORMANT Address <b>Mrs. Helen Litsinger Manchester, Md. (Wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1968</b> , to <b>May 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 10, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John S. Harshey, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>5/10/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>					22e. ADDRESS <b>8 Archer St. Westminster, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 13, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville Balto. Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Tipton - Eline Funeral Home Hampstead, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

06902				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06909				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
ANNIE P. LONGABARGER							Month	Day	Year	258 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		April 29-1879			89 YRS.		MONTHS	DAYS	HOURS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MARYLAND		U.S.A.				CARROLL Co. Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER			CARROLL CO. GEN. HOSEY CLOTHING FACTORY EMPLOYEE									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND			CARROLL		WESTMINSTER				12 NEW WINSOR ROAD			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
JOHN T. PRICE						LOUISE A. CASE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
			213-05-3865		W. ROBERT LONGABARGER			SAME ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441.1 CIRCULATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) THORACIC AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS, GENERALIZED										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
										1 HOUR		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
451 X ACUTE BRONCHITIS												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5/13, 1968, to 5/16, 1968, that (I) (we) last saw the deceased alive on 5/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Vincent J. Perocci M.D. DEGREE										22c. DATE SIGNED 5/16/68		
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			5/20/68		ST. JOHN'S CATHOLIC CEM.			WESTMINSTER, CARROLL MD				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
J. S. Myers Jr., Westminster, Md.								MAY 20 1968		Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1734  
30M RE 1/78

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Raymond</b> <b>Merrick</b> <b>McAfee</b>						2a. DATE OF DEATH Month <b>5-29</b> Day <b>68</b> Year <b>1968</b>			2b. HOUR <b>6:45 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1900-11-15</b>			6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Washington</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not State give street address) <b>Springfield Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Trimmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Mfg.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2811 Locust Street</b>			
14. FATHER'S NAME First <b>Samuel</b> Middle <b>L</b> Last <b>McAfee</b>			15. MOTHER'S MAIDEN NAME First <b>Alveta</b> Middle <b>Louise</b> Last <b>Slick</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-09-5531</b>		17. INFORMANT <b>Records-Springfield State Hospital</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Acute posterior myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arteriosclerosis with thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4201</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days 4 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cronic Brain Syndrome Associated With Cerebral Arteriosclerosis With Psychotic Reaction</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>5</b> Day <b>29</b> Year <b>1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <b>1-7-64</b> City or Town <b>5-29-68</b> County <b>Washington</b> State <b>Md.</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-7-64</b> , 19 <b>5-29-68</b> , that (I) (we) last saw the deceased alive on <b>5-29-68</b> , 19 <b>5-29-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Octavio Ruiz</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5-30-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Octavio Ruiz, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital Sykesville, Md. 21784</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington Md.</b>					
24. FUNERAL DIRECTOR <b>Wm. C. Horst</b>						ADDRESS <b>1601 Md. Pennsylvania Ave.</b>		25a. REC'D BY REGISTRAR <b>JUN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]  
DATE: [Illegible]  
FROM: [Illegible]  
TO: [Illegible]  
[The remainder of the memorandum body is illegible due to extreme fading.]

W. J. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1-48

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Louise</b>		First Middle Lost		2a. DATE OF DEATH Month <b>5/3/68</b> Year <b>1968</b>		2b. HOUR <b>5:15p</b> M	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>unknown</b>		6. AGE (In years lost birthday) <b>80?</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County,</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield St. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housework</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balto. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <b>1402 Mount Street</b>		14. FATHER'S NAME First <b>Tom</b> Middle <b>Caster</b> Lost		15. MOTHER'S MAIDEN NAME First <b>Henrietta</b> Middle <b>Caster</b> Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129</b> <u>uremic acidosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4227</b> (b) <u>renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic cardiovascular disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CBS, associated with cerebral arteriosclerosis with psychotic reaction.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25/66</b> to <b>5/3/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/3/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Antonius Glahn</i> DEGREE <b>MD</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>5/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Antonius Glahn</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21781</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetry</b>		23d. LOCATION (City or Town) (County) (State) <b>A A County Md</b>	
24. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W North Ave</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 13 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First <b>Julia C.</b>		Middle <b>(NMN)</b>		Last <b>Mobley</b>		2a. DATE OF DEATH Month <b>5/9/68</b> Year		2b. HOUR <b>11:00</b> AM		
3. SEX <b>Female</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>3/8/1902</b>			6. AGE (In years) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>S.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll County,</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Balto. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3312 Woodland Avenue</b>			
14. FATHER'S NAME First <b>Jonas</b> Middle <b>Cunningham</b> Last					15. MOTHER'S MAIDEN NAME First <b>Raechel</b> Middle <b>Robinson</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>				16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple infected bed sores</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4221</b> (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CBS, associated with senile brain disease with psychotic reaction.</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>9/28/66</b> , 19__, to <b>5/9/68</b> , that (I) (we) last saw the deceased alive on <b>5/9/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Dr. Antonius Glahn</b>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>May 9, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>						22e. ADDRESS <b>Sykesville, Md. 21784 Springfield State Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>5-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carver Mem. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Laurel, Md.</b>					
24. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>						ADDRESS <b>1701 Laurens St.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Figure 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06913

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>G.</b> Last <b>MURADIAN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 68</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 5, 1900</b>
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Turkey</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George Muradian</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Muradian</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Wife</b> <b>Ellen Muradian</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 CIRCULATORY COLLAPSE</b> DUE TO (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIO SCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b> <b>30 MIN</b> <b>5+ YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>4201 HYPOTHYROIDISM, PEPTIC ULCER</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/6/1956</b> to <b>5/3, 1968</b> , that (I) (we) last saw the deceased alive on <b>4/24 1968</b> , and that death occurred at <b>430A</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>Charles Savarese M.D.</b>		22b. DATE SIGNED <b>5/3/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES SAVARESE, M.D.</b>		22d. ADDRESS <b>11125 ROCKVILLE PK. ROCKVILLE (MONT) M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>5-8-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 13 1968</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last <b>MARY ELIZABETH NICKOLES</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>5-13 1968</b> 2b. HOUR <b>8:30 A.M.</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 23, 1918</b>		6. AGE (in years last birthday) <b>49 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.					
10. CITY OR TOWN OF DEATH <b>SYkesville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mineral Hill Road</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			
12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. CITY OR TOWN <b>SYkesville</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET AND NUMBER <b>Mineral Hill Road</b>				14. FATHER'S NAME First Middle Last <b>William - Luers</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Florence - Keck</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>Mr. Victor Nickoles SYkesville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis with Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <b>Hypertension</b> (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>39-40</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William Speicher</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>5-13-68</b>			
EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>5-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>SYkesville Md.</b>			
24. FUNERAL DIRECTOR <b>Nancy W. Haight</b>				ADDRESS <b>Sykesville, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>CARL DONALD NYGREN</b>					2a. DATE OF DEATH Month <b>5</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>10:32</b> P.M.	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 8, 1911</b>		6. AGE (In years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>10</b> HOURS <b>32</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL Co. GEN. HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRIAL</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> 13b. COUNTY <b>CARROLL</b>			13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD #5</b>		
14. FATHER'S NAME First <b>DOHENA</b> Middle <b>NYGREN</b> Last <b>NYGREN</b>			15. MOTHER'S MAIDEN NAME First <b>LILLIE</b> Middle <b>OGG</b> Last <b>OGG</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give war or dates of service) <b>WW II</b>			16b. SOCIAL SECURITY NO. <b>216-10-0061</b>		17. INFORMANT <b>MRS CARL D. NYGREN</b>		Address <b>MARYLAND WESTMINSTER RD #5</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>HOURS</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/9, 1968</b> , to <b>5/9, 1968</b> , that (I) (we) last saw the deceased alive on <b>5/9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Vincent J. Krowinski M.D.</b>					22c. DATE SIGNED <b>5/9/68</b>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BELAIR MEM. GARDENS</b>		23d. LOCATION (City or Town) (County) (State) <b>BEL AIR HARTFORD MD</b>			
24. FUNERAL DIRECTOR <b>J. S. Myers Jr. Westminster, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

5. The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

6. The sixth part of the report deals with the future of the country. It is a very interesting and informative study of the country's future. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's future.

7. The seventh part of the report deals with the conclusion of the study. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 1 A. M	
Benjamin Franklin Overholtz					May 26, 1968			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH April 17 1900			6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Ave. Florioville			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER North Ave. Florioville		
14. FATHER'S NAME John Overholtz		15. MOTHER'S MAIDEN NAME Clemmie Lake						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 214-03-3361		17. INFORMANT Address Mrs Alice Overholtz Sykesville, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary thrombosis and cardiac arrest.</u> 1958 through 5/26/68								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1958, 19, to May 26, 1968, that (I) (we) last saw the deceased alive on May 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Howard E. Hall				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 27, 1968		
22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.				22e. ADDRESS Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 68		23c. NAME OF CEMETERY OR CREMATORY Hinterburn Chapel		23d. LOCATION (City or Town) (County) (State) Clarksville Howard, Md		
24. FUNERAL DIRECTOR Highland-Slack Funeral Home				ADDRESS Ellicott City, Md		25a. REC'D BY REGISTRAR DATE MAY 31 1968		
						25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06917

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>JOSEPHINE (NMN) PIRILLO</b>			2a. DATE OF DEATH Month <b>MAY</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR A <b>7:00</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-7-1881</b>		6. AGE (In years last birthday) <b>86</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA Naturalized</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Own business</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fruit Market</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>95 E. Main St.</b>	
14. FATHER'S NAME First <b>Michael</b> Middle <b>Emil</b> Last <b>Meloe</b>			15. MOTHER'S MAIDEN NAME First <b>Michellina</b> Middle <b>Scrivano</b> Last <b>Unk</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-54-8042</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4129</b> IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia, terminal</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>4200</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>  <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CBS associated with senile brain disease, with psychotic reaction</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-3-66</b> , 19__, to <b>5-27-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-27-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Agustin del Campo</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>5-27-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>Marilyn M. Sowers, Hafer-Sowers Funeral Home, 60 W. Main, Frostburg</b>				25a. REC'D BY REGISTRAR <b>JUN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>JENNY LIND POND</b>			2a. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>2:05</b> P.M.						
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 27 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.						
10. CITY OR TOWN OF DEATH <b>FINXSBURG RT#1</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>OFF OLD ROUTE 140</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>FINXSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>OFF OLD ROUTE 140</b>			
14. FATHER'S NAME First <b>?</b> Middle <b>SMITH</b> Last <b>SMITH</b>			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>216-20-1357A</b>		17. INFORMANT <b>MR. CLARENCE E. POND</b>		Address <b>SAME ADDRESS</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNILATERAL RENAL DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>"</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443X</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/11, 1968</b> , to <b>5/25, 1968</b> , that (I) (we) last saw the deceased alive on <b>5/25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Vincent J. Kroc</b> MD					22c. DATE SIGNED <b>5/25/68</b>		22d. PHYSICIAN'S NAME (Type) <b>ANCHOR ST. WESTMINSTER MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE BALTO. MD.</b>						
24. FUNERAL DIRECTOR <b>R.S. Myers, Jr. Westminster Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (M)  
30M REV. 1-68

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First JOHN		Middle ELGIN		Last POOLE		2a. DATE OF DEATH Month 5 Day 30 Year 68		2b. HOUR P 5:30 M				
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH 12/05/02			6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.						
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager			12b. KIND OF BUSINESS OR INDUSTRY retail store						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montg. ✓			13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 26 Manakee Street					
14. FATHER'S NAME First JOHN			Middle ELGIN			Last POOLE			15. MOTHER'S MAIDEN NAME First LAURA			Middle L.		Last REED	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578 44 0519			17. INFORMANT Hospital records			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident (thrombosis)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3327</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CBS assoc. with circulatory disturbance with psychotic reaction</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (if this hospital) attended the deceased from <u>3/31</u> , 19 <u>65</u> , to <u>5/30</u> , 19 <u>68</u> , that (h) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>68</u> , and that in (h) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (h) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Isak Hapner</u>			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 5/30/68								
22d. PHYSICIAN'S NAME (Type) Isak Hapner, M. D.			22e. ADDRESS Springfield State Hospital												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/3/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn			23d. LOCATION (City or Town) Rockville		(County) Montgomery		(State) Md.			
24. FUNERAL DIRECTOR Tyson Wheeler			ADDRESS 1331 Rockville Pike Rockville, Maryland				25a. REC'D BY REGISTRAR DATE JUN 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

2102

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>WILLIAM HERBERT POWELL</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>1:40</b> PM			
3. SEX <b>Male</b>	4. RACE <b>Mulato</b>	5. DATE OF BIRTH <b>3/15/13</b>	6. AGE (in years last birthday) <b>55</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>6</b> Year <b>1968</b>			2d. HOUR <b>1:40</b> PM
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Musician</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution; Residence before admission) STATE <b>Maryland</b> COUNTY <b>Balto. City Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>708 W. Mosher Street</b>		
14. FATHER'S NAME First <b>James Powell</b> Middle Last			15. MOTHER'S MAIDEN NAME First <b>Ella Money</b> Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>220-07-7471</b>		17. INFORMANT ADDRESS <b>Records, Springfield State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to aspirated food in both bronchi</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>9-21-7</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Springfield State Hosp.</b>		21f. LOCATION Street or R.F.D. No. <b>Sykesville</b>		City or Town <b>Carroll</b>		State <b>Md.</b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>5-6-68</b>			
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>			23d. LOCATION (City or Town) <b>A A</b> (County) <b>Md</b>		
24. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W North Ave</b>				25a. REC'D BY REGISTRAR <b>MAY 10 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06914		06921								
1. DECEASED-NAME (Type or print) First Middle Last <b>WALTER SCOTT Price</b>					20. DATE OF DEATH Month Day Year <b>May 14, 1968</b>			2b. HOUR <b>10:45</b>		
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH <b>December 30, 1887</b>			6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 2</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 2</b>	
14. FATHER'S NAME First Middle Last <b>John R. Price</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Arabelle Robinson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-36-9639</b>		17. INFORMANT Address <b>Mrs. Emma R. Price, Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASHD, Auricular fibrillation,</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary thrombosis, cardiac arrest,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Obesity and arteriosclerosis, generalized.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1960 through 5/14/68</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19____, to <b>May 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Howard E. Hall</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <b>May 14, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Howard E. Hall, M.D.</b>					22e. ADDRESS <b>Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>May 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chestnut Grave</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Maryland</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>						25a. REC'D BY REGISTRAR DATE <b>MAY 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION

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06915

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06922

1. DECEASED NAME (Type or Print) <b>CALVIN KELLY PURDUM</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>6:30</b> M <b>P</b>				
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Oct. 28, 1919</b>	6. AGE (In years last birthday) <b>48</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>5</b> Year <b>1968</b>			2d. HOUR <b>7:30</b> M <b>P</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll, Md.</b>				
10. CITY OR TOWN OF DEATH <b>Taylorsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R.D. 6</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Parts Manager</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Woodbine</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b></b>
14. FATHER'S NAME First <b>Calvin</b> Middle <b>N.</b> Last <b>Purdum</b>			15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b></b> Last <b>Kelly</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-05-2280</b>			17. INFORMANT <b>Mrs. Mary C. Purdum</b>			ADDRESS <b>Same As #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull &amp; Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>8254</b>										
19a. DATE OF OPERATION <b></b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>			21b. TIME OF INJURY Month, Day, Year <b>5-5-68</b> HOUR A.M. <b>6:30</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Ran Through Stop &amp; Blinker Light</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, office building, etc.) <b>Intersection Route 26 &amp; 27 West Westminster Carroll Md</b>			21f. LOCATION Street <b>R.D. 6</b> City or Town <b>Carroll</b> County <b>Carroll</b> State <b>Md</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>5-5-68</b>		
EXAMINER'S NAME (Type) <b>Dr. W. Glenn Speicher</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADJUTANT <b>W. C. Westminister Carroll</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>5/8/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Memorial Gardens</b>			23d. LOCATION (City or Town) (County) (State) <b>Carroll, Md.</b>		
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>				ADDRESS <b></b>		25a. REC'D BY REGISTRAR <b>MAY 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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GALVIN KELLY JORDON

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <b>JAMES WALTER RICKETTS III</b>			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5-17 1968		2b. HOUR- A M 2:25		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>July 7, 1945</b>	6. AGE (In years last birthday) <b>22</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 5 Day 17 Year 1968		2d. HOUR- A M 3:05		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rural</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME <b>James Walter Ricketts, Jr.</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Irene Ivy Wood</b>			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-44-4540</b>		17. INFORMANT ADDRESS <b>J.W. Ricketts, Jr., R #1M, Taneytown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 816.9 IMMEDIATE CAUSE (a) <b>Fractured Skull and Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>8234</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5-17 1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Car ran off road struck telephone poles &amp; State killer</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>Route 140</b>			21f. LOCATION Street or R.F.D. No. <b>RD 1</b>		City or Town <b>Westminster</b>		County <b>Carroll</b> State <b>Md</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>5-17-68</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>May 19, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace Reformed Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Taneytown, Maryland</b>			
24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son</b>			ADDRESS <b>Taneytown, Maryland</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-5  
30M REV. 1-68

MEDICAL CERTIFICATION

1. DECEASED-NAME				First		Middle		Last		2a. DATE OF DEATH			2b. HOUR			
(Type or print)				DAVID		ALFRED		ROSS, SR.		MAY 6, 1968			6:15 P M			
3. SEX		Male		4. RACE		Negro		5. DATE OF BIRTH		6-28-03		6. AGE (In years lost birthday)		64 YRS.		
7a. BIRTHPLACE (State or foreign country)		North Carolina		7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Carroll Md.			
10. CITY OR TOWN OF DEATH		Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		Maryland		13b. COUNTY		Baltimore City		13c. CITY OR TOWN		Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
														4122 Kathland Ave.		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last		
		Ethrum				Ross				Carrie				Quick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		No		(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		218-05-3750		17. INFORMANT		Address		
												Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalopathy due to arteriosclerosis</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>334X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>3-29-68</u> , 19 <u>  </u> , to <u>5-6-68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>3-6-68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Alberto Gonzalez</u>										DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) Alberto Gonzalez, M. D.												22e. ADDRESS		Springfield State Hospital Sykesville, Maryland 21784		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)										
Burial		5/10/68		Carver Memorial Park		Laurel Maryland										
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Herbert E. Nutter-3035 W. North Ave.										MAY 7 1968		<u>Charles Judge</u>				

43036

UNITED STATES OF AMERICA

71001





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06913

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06925

1. DECEASED-NAME (Type or Print) <b>GLADYS ELLEN ROWE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>3:30</b> MIN <b>P</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>JULY 23 - 1906</b>	6. AGE (In years last birthday) <b>61</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>18</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.		
10. CITY OR TOWN OF DEATH <b>UNION BRIDGE RURAL</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MT UNION ROAD</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>UNION BRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>ROUTE 1</b>
14. FATHER'S NAME First <b>CHARLES</b> Middle <b>MARTIN</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>SADIE</b> Middle <b>HALL</b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>STERLING N ROWE</b>			ADDRESS <b>UNION BRIDGE MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull Fractured Neck</b> DUE TO, OR AS A CONSEQUENCE OF <b>Multiple Injuries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>7734</b>								
19a. DATE OF OPERATION <b>7734</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>3:30</b> P.M. <b>5-18 1968</b>		21c. HOW INJURY OCCURRED (Enter name of injury in Part 1 or Part 2 (Item 18.) <b>car Ran off side of Road</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, school, office building, etc.) <b>W Union Road</b>		21f. LOCATION Street or R.F.D. No. <b>Rd 1</b>		City or Town <b>Union Bridge</b>		State <b>Carroll Md</b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>W Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>5-18-68</b>		
EXAMINER'S NAME (Type) <b>W GLENN SPEICHER</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS <b>120 S. Westchester Carroll Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAY 21-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		23d. LOCATION (City or Town) <b>NEW WINDSOR RURAL MD</b> (County) <b>CARROLL</b> (State) <b>MD</b>		
24. FUNERAL DIRECTOR <b>D D Hartzler &amp; Sons</b>				ADDRESS <b>Union Bridge Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

08830

ADOLPH E. BROWN, JR. (1914-1981)

81233

FOR THE  
FEDERAL DEPT.

CLARK, J. (1914-1981)



ADOLPH E. BROWN, JR. (1914-1981)

CLARK, J. (1914-1981)

ADOLPH E. BROWN, JR. (1914-1981)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
Item #2a Film #G400 5/20/68 ph		06926									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
HARRIET MARGARET Runkle								May 11 1968		15 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		White		Aug 28		87 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pa		U.S.A				Carroll		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Manchester		Lynn View		Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		Carroll		Manchester				222 York St			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Oliver						Runkle		Mandella		Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		216-46-1587		MAY SMITH		Manchester, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Dis										5 yrs	
4129 DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4221 Diabetes mellitus Bronchial Arthritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 48, to MAY 11, 19 68, that (I) (we) last saw the deceased alive on MAY 7, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
WH Foard MD		5/11/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
WH Foard MD		Manchester, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 13, 1968		Manchester Cemetery		Manchester Carroll Co. Md					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Tipton - Eline Funeral Home Hampstead, Md.				MAY 15 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06920		06927	
1. DECEASED-NAME (Type or print) First Middle Last GRACE MAY SCHNAUBLE		2a. DATE OF DEATH Month Day Year MAY 27 1968	
3. SEX FEMALE		4. RACE WHITE	
5. DATE OF BIRTH AUG 16 1888		6. AGE (In years last birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.	
10. CITY OR TOWN OF DEATH RT #2 WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MURKLE ROAD	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) - STATE MD		13b. CITY OR TOWN WESTMINSTER	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER MURKLE ROAD	
14. FATHER'S NAME First Middle Last KINSEY WILLIAMS		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE E. WOLKINGTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 215-347244	
17. INFORMANT LORETTA KOONTZ		18. ADDRESS ROUTE #2 WESTMINSTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4419 ANEURYSM OF AORTA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC C.V. DIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 4 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 451X			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 1968 to MAY 1968 that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Daniel J Welliver MD		22c. DATE SIGNED 5-27-68	
22d. PHYSICIAN'S NAME (Type) DANIEL I WELLIVER		22e. ADDRESS 1912 DUFF ROAD WESTMINSTER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/30/68	
23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEM.		23d. LOCATION (City or Town) (County) (State) GAMBER CARROLL MD	
24. FUNERAL DIRECTOR James G. Saffell		25a. REC'D BY REGISTRAR DATE MAY 29 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			



12236

CONTINUED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>FREDERICK CONRAD SCHUCHHARDT</b>			2a. DATE OF DEATH Month Day Year <b>5 10 68</b>			2b. HOUR <b>3:00</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>08/02/93</b>		6. AGE (In years lost birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Store keeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>HENRY SCHUCHHARDT</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET DECKER</b>		13e. STREET AND NUMBER <b>112 Cedarcroft Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-01-9789</b>		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pyelonephritis, right kidney</b> <b>4200</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days - weeks</b> <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CBS assoc. with cerebral arteriosclerosis with psychotic reaction</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>04/05/65</b> , 19__, to <b>05/10/68</b> , 19__, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>05/10/68</b> , 19__, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Hein, Klaatsch, M. D.</b>				22c. DATE SIGNED <b>5/10/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Hein, Klaatsch, M. D.</b>				22e. ADDRESS <b>Springfield State Hospital, Sykes., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>				25a. REGD. BY REGISTRAR DATE <b>MAY 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First BENJAMIN		Middle FRANK		Last SCOTT		2a. DATE OF DEATH Month Day Year MAY 31, 1968			2b. HOUR 3:00 P.M.
3. SEX Male			4. RACE White			5. DATE OF BIRTH 2-5-1899			6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore City			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2426 Edmondson Ave.		
14. FATHER'S NAME First Middle Last XXXX Benjamin P. Scott			15. MOTHER'S MAIDEN NAME First Middle Last XXXX Mary Hartman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. Unk.			17. INFORMANT Address Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to ribs, lung, liver and</u> <u>jaw.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of right kidney, removed at operation.</u> <u>year</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia.</u> <u>days</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Schizophrenic reaction, paranoid type</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-5-26</u> , 19 <u>  </u> , to <u>5-31-68</u> , 19 <u>  </u> , that (I) (we) lost saw the deceased alive on <u>5-31-68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Octavio A. Ruiz</u>			DEGREE Octavio A. Ruiz, M. D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 5-31-68			
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.			22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 6-3-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06923

06930

1. DECEASED-NAME (Type or Print) <b>MARGUERITE ANNIE SIMPSON</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>5</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR OF DEATH <b>3:30 P M</b>				
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>JULY 23-1906</b>	6. AGE (in years last birthday) <b>61</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>5</b> Day <b>18</b> Year <b>1968</b>			2d. HOUR <b>3:57 P M</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>				
10. CITY OR TOWN OF DEATH <b>UNION BRIDGE RURAL</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MT UNION ROAD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE WIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>			13c. CITY OR TOWN <b>UNION BRIDGE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>CHARLES</b> Middle <b>MARTIN</b> Last <b>HALL</b>			15. MOTHER'S MAIDEN NAME First <b>SADIE</b> Middle <b>HALL</b> Last <b>HALL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT ADDRESS <b>R1 MONROE SIMPSON UNION BRIDGE MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull, crushed chest</b> DUE TO, OR AS A CONSEQUENCE OF <b>Multiple injuries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>2234</b>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>3:30 P.M.</b> <b>5-18 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>car ran off left side road</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>MT Union Road</b>		21f. LOCATION Street or R.F.D. No. <b>Rd 1</b> City or Town <b>Union Bridge</b> County <b>Carroll</b> State <b>MD</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>5-18-68</b>		
EXAMINER'S NAME (Type) <b>W GLENN SPEICHER</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAY 21-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		23d. LOCATION (City or Town) <b>NEW WINDSOR</b> (County) <b>CARROLL</b> (State) <b>MD</b>				
24. FUNERAL DIRECTOR <b>D D Hartzler &amp; Sons, Union Bridge, Md</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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ADDITIONAL EXAMINER'S CERTIFICATE OF DEATH

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IN THE DEPT.



NAME OF DECEASED	
AGE	
SEX	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
SIGNATURE OF EXAMINER	
DATE	
PLACE	
OFFICE	
COUNTY	
STATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15M  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Ruth Victoria Sodergren</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>May 25, 1968</b>			2b. HOUR <b>3:45aM</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>4-22-1897</b>			6. AGE (In years last birthday) <b>71</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b> Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield St. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Johann Victor Sodergren</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lucy Groat</b>			13e. STREET AND NUMBER <b>14 E. Antietam Street</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-09-2808</b>			17. INFORMANT <b>Springfield St. Hospital Records</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastric Dilatation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pyloric stricture + chronic gastricular</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>aspiration Bronchopneumonia</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>months</b> <b>day</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>545X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-18-68</b> , 19__, to <b>5-25-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>5-25-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Glocrito Sagisi</b>									22c. DATE SIGNED <b>5-25-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Glocrito Sagisi</b>									22e. ADDRESS <b>Springfield St. Hospital.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>5/29/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASHINGTON CO., MD.</b>		
24. FUNERAL DIRECTOR <b>Charles M. Rouger</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR DATE <b>MAY 31 1968</b>		
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



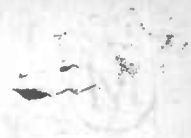
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MAY 3 1968																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First BERNARD			Middle LEE			Last TAYLOR			2a. DATE OF DEATH Month Day Year May 3, 1968			2b. HOUR 6:15 A.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 4/29/20			6. AGE (In years last birthday) 48 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) West Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll County, Md.								
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Balto. City Baltimore			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER No fixed address								
14. FATHER'S NAME First Middle Last Sanford E. Taylor			15. MOTHER'S MAIDEN NAME First Middle Last M. Verna Virgie Cutwright														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WWII			16b. SOCIAL SECURITY NO. 236-16-6593			17. INFORMANT Address Records, Springfield State Hospital											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute massive myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis of left coronary artery DUE TO, OR AS A CONSEQUENCE OF (c) 410.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS, associated with circulatory disturbance (stroke, cerebral thrombosis) without qualifying phrase																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 12/7/67, 19__, to 5/3/68, 19__, that (I) (we) last saw the deceased alive on 5/3/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Octavio A. Ruiz			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED May 3, 1968								
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.			22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 5-7-1968			23c. NAME OF CEMETERY OR CREMATORY Phillips Cemetery			23d. LOCATION (City or Town) (County) (State) Coalton, West Virginia								
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH				06933	
1. DECEASED-NAME (Type or print) First Middle Last <b>JESSE EDWIN TURNER</b>			2a. DATE OF DEATH Month Day Year <b>MAY 1 1968</b>		2b. HOUR <b>9:30 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>February 8, 1888</b>		6. AGE (In years lost birthday) YRS. MONTHS DAYS <b>79</b>	
7a. BIRTHPLACE (State or foreign country) <b>Richmond Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Manchester</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Longview Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired.) <b>Electrician</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Finksburg Md</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>RD #1</b>
14. FATHER'S NAME First Middle Last <b>QUINN Turner</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ETHEL EUGENE JAMES ?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, n.g. or unknown (If yes give war or dates of service) <b>Yes World War I</b>		16b. SOCIAL SECURITY NO. <b>4201</b>		17. INFORMANT Address <b>Tippy Eva TURNER Finksburg Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Heart Disease</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Atherosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>April 28</b> , 19 <b>68</b> , to <b>5-1</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph E. Bush MD</b>				22c. DATE SIGNED <b>5-1-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush MD</b>				22e. ADDRESS <b>MANCHESTER Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>5/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINE GROVE CEMETERY</b>	
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md</b>		23d. LOCATION (City or Town) (County) (State) <b>MT AIRY CARROLL MD</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAY 6 1968</b>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "WILLIAM" and "MAY" are faintly visible.]*

*[Faint vertical text along the right margin, likely bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 118 (4)  
30M REV 1/68

06927 Item #6 Film#G400 506168												06934													
1. DECEASED-NAME (Type or print) First Middle Last ANNE PEARLY WALTZ												2a. DATE OF DEATH Month Day Year 5 13 68												2b. HOUR 12 AM	
3. SEX F			4. RACE W			5. DATE OF BIRTH 6 APRIL 1903						6. AGE (In years lost birthday) 64 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH CARROLL Md.													
10. CITY OR TOWN OF DEATH WESTMINSTER						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO GENERAL						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEKEEPER						12b. KIND OF BUSINESS OR INDUSTRY OWN HOME							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.						13b. COUNTY CARROLL						13c. CITY OR TOWN UNIONTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER CLEAR RIDGE									
14. FATHER'S NAME First Middle Last JOSEPH PEARLY						15. MOTHER'S MAIDEN NAME First Middle Last SOPHIA (UNKNOWN)																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO. 217-05-7349A				17. INFORMANT Address ROY E WALTZ LINWOOD MD																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 10xemia 444.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 570 (b) Hemorrhagic infarction Large & Small bowel DUE TO, OR AS A CONSEQUENCE OF (c) Mesenteric Arterial Thrombosis														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days 4 days											
														PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterial & venous thrombotic disease with terminal infarction											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 5/12, 1968 to 5/13, 1968, that (I) (we) last saw the deceased alive on 5/13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE Richard E. Jones												DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 5/13/68									
22d. PHYSICIAN'S NAME (Type) Richard E. Jones												22e. ADDRESS Carroll County General Hosp.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5/15/68		23c. NAME OF CEMETERY OR CREMATORY LUTHERAN				23d. LOCATION (City or Town) (County) (State) UNIONTOWN MD															
24. FUNERAL DIRECTOR D. Hartley & Sons New Windsor												25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE Francis J. Jones											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1968</u>		2b. HOUR <u>11:15</u> P M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10/5/94</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County,</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balto. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1207 Delwood Avenue</b>	
14. FATHER'S NAME First <b>Irving</b> Middle <b>Ward</b> Last <b>Ward</b>		15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Margaret</b> Last <b>Margaret</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>None</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>265-10-2328-A</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic acidosis</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/8/68</b> , 19____, to <b>5/8/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>5/8/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Octavio A. Ruiz</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5/8/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>		22e. ADDRESS <b>Sykesville, Maryland 21784 Springfield State Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>5-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Freedom</b>		23d. LOCATION (City or Town) (County) (State) <b>Sykesville, Md.</b>			
24. FUNERAL DIRECTOR <b>Harvey W. Knight</b>		ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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VR A13 (1)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Ethel Susan Wildasin						MAY 13 1968		10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR		
Female		white		July 20 1896		71 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Carnwell Md.		USA				Carnwell				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Manchester			203 York St.			Housewife		Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Carnwell		Manchester		YES		203 York St	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Jonas Wither			Martha Hawn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			218-03-260		John Wildasin, Manchester, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Coronary Thrombosis								1/2 hr		
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis 5 yr										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 1952, to May 13, 1968, that (I) (we) last saw the deceased alive on Jan 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W H Foard M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
22c. DATE SIGNED 5/13/68										
22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D. ADDRESS Manchester, Md 21102										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										
23b. DATE May 16, 1968										
23c. NAME OF CEMETERY OR CREMATORY John Luther Miller Cem.										
23d. LOCATION (City or Town) (County) (State) Westminster Carro.. Co. Md.										
24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md.										
25a. REC'D BY REGISTRAR DATE MAY 17 1968										
25b. REGISTRAR'S SIGNATURE Charles Judge										

MEDICAL CERTIFICATION

15236



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <span>06930</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>06937</span> </div>											
1. DECEASED-NAME (Type or print)			First Middle Last <b>Lillian G. Wise</b>			2a. DATE OF DEATH Month Day Year <b>May 23, 1968</b>			2b. HOUR <b>7 A M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1896</b> <del>May</del> <b>Sept 4,</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hampstead</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>21 S. Main St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>21 S. Main St.</b>		
14. FATHER'S NAME First Middle Last <b>Joseph Teal</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna M. Miller</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-12-3113</b>		17. INFORMANT Address <b>Mr. Harry Wise Hampstead, Md. 21074</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cross my Arteries Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Deauche Incurtus (Senn)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>10 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>7-18</b> , 19 <b>67</b> , to <b>5-23</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5-22</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>M.C. Porterfield</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-24-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield, M.D.</b>				22e. ADDRESS <b>Hampstead, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 25, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reisterstown Meth. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Reisterstown, Md.</b>					
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAY 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847